

of trial. In disease or injury of the lower neurones every gain in motion, however slight, was gladly welcomed, and if hemiplegics could be helped by nerve transplantation, there was the added hope of lessening the cerebral spasm to which Dr. Spiller had referred, and which in one case coming under the speaker's observation was so troublesome that the arm was amputated at the shoulder at the request of the patient. The brilliant result in Dr. Elsberg's case demonstrated the possibility of transplanting the spinal accessory without causing associated movements, which seemed to be the chief drawback to choosing this nerve in preference to the hypoglossal.

Dr. Spiller, in closing, said the statement made by Dr. Taylor that in late cases, where the paralysis had existed for a long time, the nerve may have disappeared, was correct. The speaker recalled such a case where the facial nerve could not be found at all. In facial palsy one of the earliest evidences of a return of power that could be elicited was a slight deepening of the naso-labial fold when the eyes were closed tightly.

Dr. Frazier, in closing, said that in his cases of nerve anastomosis the hypoglossal had been selected in preference to the spinal accessory purely on theoretical grounds and a study of former operations, and also because associated movements had followed the selection of the spinal accessory. The case reported by Dr. Elsberg was the first one in which these associated movements had not occurred. Henceforth, Dr. Frazier said, he would favor the end-to-side anastomosis in preference to the end-to-end method.

Dr. Clark, in closing, said he thought the proper time to operate could be fairly accurately decided upon by the results of the electrical tests, and he did not think it wise to fix an arbitrary period of time. In most forms of peripheral neuritis the electrical tests formed a basis of prognosis that was almost absolute. Certainly, at the end of three or four months, if the electrical changes should complete degeneration of the nerve and there was no evidence of repair, he thought an operation would be indicated. At the same time, if one preferred to wait a year, or even thirty years, he saw no objection to it.

Dr. Taylor said the disappearance of tearing to which Dr. Elsberg referred in his case had also been noted in one of his cases. The operative damage to the hypoglossal and the tongue symptoms resulting therefrom were only temporary, and he did not think they should be looked upon as a serious objection to the selection of that nerve for the anastomosis.

PHILADELPHIA NEUROLOGICAL SOCIETY.

March 28, 1905.

The President, DR. JOSEPH SAILER, in the Chair.

A Case with Some of the Symptoms of Multiple Sclerosis Due to Trauma.—This paper was presented by Dr. Ralph Pemberton. On the 16th of January, 1905, the man fell from the upper girders of the Subway, where he was working, a distance of about 16 feet, though whether he stepped into some opening or lost his balance while at work he cannot say. He became unconscious and does not know how he struck, though he fell on a cement flooring. He was taken to the Medico-Chirurgical Hospital and was treated there for four weeks, of which time he can give no satisfactory account, though he was not constantly in bed, and was told that at times he had to be catheterized. On two occasions plaster jackets were applied, the second of which alone he remembers. He

does not know how long he was unconscious, and since the fall he has had constant abdominal tenderness, pain in the back and constipation, and he states that before the fall he had been feeling well except for a bad cold.

He has never been subject to fits or periods of unconsciousness as far as he knows, and has always been of an active habit.

Examination.—He is a well-built and symmetrically developed young man. No paralysis of facial or ocular muscles is present, pupillary reactions are normal and there is no nystagmus. The tongue protrudes promptly in mid-line, and is very slightly tremulous. There is at times an antero-posterior tremor of the head, especially when he is standing and therefore supporting the head, but also when in bed and when a voluntary act, as touching his fingers to his nose, is attempted. His mentality seems fair and he answers questions well, but his speech is slightly tremulous, and a relative states that it was not so formerly. Chest and intra-thoracic organs and abdomen seem normal, except that over most of the abdomen is a diffuse light-brown discoloration extending over the genitalia, which the patient says is congenital.

When first admitted to the hospital patient complained of considerable abdominal pain and tenderness to palpation, most of which disappeared by the next day. The spinal column is straight and presents no abnormality to inspection, but in the lower thoracic region, extending down to about the sacrum, pressure over the spines of the vertebræ causes pain. Pain is also elicited by pressure over the region of the left tuber ischii.

The patient lies quietly in bed and can move both arms freely, though a coarse tremor is evident on both sides, especially the right, when any voluntary act is attempted, and is most marked in the finger to nose movement. This he performs rather slowly, uncertainly and waveringly even with his eyes open, but better with the left hand. Occasionally when the limb is quiet the tremor is present on the right side, but on extending both hands the fingers do not seem to be involved. Muscular power in the hands and arms is fair and equal, though hardly commensurate with his general musculature. The biceps tendon reflexes seem about equal and very slightly, if at all, exaggerated on both sides, and the triceps reflexes are about normal.

The legs lie quietly and can be raised freely, move at all joints and show a fair degree of power, though he complains that flexion of thighs on abdomen causes pain in the groins.

The patellar reflexes are prompter than normal and somewhat exaggerated; there is no patellar clonus, though a tendency to it is sometimes apparent, and no ankle clonus is present. Plantar stimulation on both sides gives some dorsal flexion of all the toes, and occasionally of the great toes alone, though the movement is hardly typical. The Achilles jerks are normally present, and tapping the patellar tendons at times throws the legs into spasm. On raising either leg voluntarily a slight intention tremor is noticeable. Sensation in all parts is apparently good. The arms are of fair musculature and size, but the legs seem small, and the calves especially are soft and flabby.

He moves slowly, gets out of bed cautiously, and walks slowly and carefully, with his back slightly bent forward, but his station is good with eyes closed or open. Walking or standing up straight causes pain in the groins, according to his statement, but when quiet in bed he is comfortable. Ophthalmoscopic examination by Dr. Oliver on March 21, 1905, for pallor of the optic discs showed the eye-grounds healthy in every detail. Since admission to the hospital two weeks ago he has improved somewhat; the intention tremor is less pronounced, and he says he feels better.

Dr. Dercum referred to a case he recorded some years ago of a man who fell from South Street bridge and afterward died. This man had

tremor as a marked symptom, but there was no change whatever in the central nervous system suggesting spinal sclerosis.

Dr. Gordon thought the intention tremor of the right hand to be the only symptom he could see of disseminated sclerosis. He called attention to the continuous passive tremor of the head. In a case which had come under his observation there was first a tremor of the head similar to this case, and it developed later as paralysis agitans, and he thought it possible that this case of Dr. Pemberton might be one of paralysis agitans.

Dr. Lloyd said this case reminded him much of the cases of hysterical tremor described by French authors. Luys once reported a case which he claimed was one of paralysis agitans, which he had cured under hypnotism with rotating mirrors. Rendu and others took exception to Luy's diagnosis, and this led Rendu to write his classical paper on hysterical tremor. Westphal also reported two cases of so-called insular sclerosis in which the autopsy revealed no lesions. In a former paper on hysterical tremor Dr. Lloyd reported a similar case. Some years ago such a case was seen at Blockley in a man who had experienced a severe earthquake shock in South America. His condition and tremor were very similar, although worse, to that of Dr. Pemberton's case, and had lasted for several years. But he eventually entirely recovered. Dr. Lloyd believed that such cases are instances of traumatic neurosis, or hysterical tremor.

Rendu pointed out the characteristics of this tremor. It is sometimes wide in range (although not always), and it is much exaggerated by voluntary motion, just as in insular sclerosis. It differs, however, from insular sclerosis in the fact that a tremor is usually felt when the patient is at rest, as by placing the hand lightly on the patient's head. This is so in Dr. Pemberton's case. Dr. Lloyd was inclined to believe that the case was one of traumatic hysterical tremor, and that the patient could be cured by suggestive therapeutics.

Dr. Spiller called attention to the fact that Dr. Pemberton's case was not reported as one of multiple sclerosis, but simply as a case with some of the symptoms of multiple sclerosis, in order to show how difficult it may be to diagnose between hysterical tremor, organic injuries of the central nervous system and multiple sclerosis.

Dr. Pemberton read a paper on the direction of turning in organic hemiplegia.

A Case of alcoholic multiple neuritis with exaggeration of the knee-jerks and a paper on the regeneration of peripheral nerves were presented by Dr. S. D. Ludlum.

Dr. J. T. Krall and Dr. T. H. Weisenburg exhibited a case of injury to the head with involvement of some of the cranial nerves.

Dr. Charles K. Mills exhibited a case of choreo-athetoid movements of one upper limb.

Dr. Eshner thought this case would recall to many members of the society the classical case of Dr. S. Weir Mitchell, in which the patient presented a violent tremor of somewhat varying character, which ceased during sleep and could be checked by lying down. For a long time Dr. Mitchell thought the condition an anomalous form of spasm or tremor of obscure origin, but of recent years he decided that the case was hysterical. Under hypnotic suggestion the man was entirely relieved. The symptoms returned, however, under some emotional strain, and they then continued until death, which occurred suddenly, and on post-mortem examination was found to be due to heart disease. No changes in the nervous system were found.

Dr. Dercum remembered the case Dr. Eshner cited, and stated that the man had no other stigmata of hysteria except the tremor. He thought this case and the one Dr. Mills exhibited very similar.

Dr. William Pickett exhibited a case with difficulty in urination.

Dr. Mills thought the case might be one of sacral tabes. He considered that the loss of the Achilles jerk was suggestive of that condition. He recalled a paper he had read several years ago on the subject of the Achilles jerk and other reflexes in which loss of the Achilles jerk was the earliest and almost the only symptom present in two cases which afterward developed other tabetic symptoms.

Dr. Gordon believed the case to be one of tabes for the following reasons: Loss of Achilles tendon reflex has been observed by many writers in the preataxic period. The knee-jerks are also diminished on both sides. The occasional pains in the legs and the condition of the pupils, also some disturbance of the function of the bladder—all these symptoms are certainly in favor of tabes. Although all the symptoms outside of the tendon Achilles reflex are not pronounced, they are nevertheless grouped together to add to the value of the complete absence of the Achilles tendon reflex.

Dr. Robert H. Chase read a paper entitled *Insane Delusions*.

Dr. Dercum said we must all admit the great rôle which the feelings play in the development of delusions. He had approached the subject of mental diseases rather from the standpoint of internal medicine than from the standpoint of psychology.

Dr. Lloyd said that Dr. Chase had given a very careful analysis and classification of delusions. While delusions may thus be classified with advantage for purposes of study, it is, of course, not possible to classify the various forms of insanity merely according to the delusions; nor, as he understood him, does Dr. Chase intend to do this.

Some of the points touched on by Dr. Chase are very profound ones. Dr. Lloyd thought one of the most interesting analyses of the distinction between emotion and intelligence has been made by Ribot in his work on the emotions, and this pursues in great detail some of the very ideas which Dr. Chase has embodied in his paper. Ribot's idea is that in the development of the mind, emotions precede the intellect; and he likens the very earliest impulses of organic life in the vegetable cell—such as the impulse to take and assimilate food—to the beginning of the emotions or impulses in the primitive animal cell. It is doubtless true that these very fundamental processes or feelings are involved in the formation of delusions. The sense of personality is altered in various ways.

Dr. Lloyd had sometimes thought that a good test would be that a man is never insane until his ego is insane. A man may have very extravagant opinions on all sorts of subjects, such as religion, politics, or every-day affairs, but he is not necessarily insane on that account. This is a matter of common observation. We all know what incredible opinions are entertained on religious subjects by wise and educated men. But these opinions are, as it were, outside the domain of the ego. They do not affect the personality of the believer. The Moslem who believed that Mahommed went to the seventh heaven and returned in an instant of time is not insane, although his belief is extravagant. But it does not involve his own ego. If, however, a man believes he is a Messiah, it is a different story. Such a man is insane. So it is with the persecutory lunatic; the whole delusional cycle centers upon the ego. It was Griesinger who also elaborated this idea of the alteration of the personality, of the sense of the ego, in insane delusions.

Dr. C. L. Leonard read a paper on the treatment of some neuralgias by the Roentgen rays.